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ABSTRACT

The Southern Rural Development Center (SRDC) at Mississippi State University aims to stimulate the creation of new partnerships to enhance rural communities' capacity to address key health issues. In 1997, SRDC hosted a conference to develop the following: partnerships among land-grant universities, the health sector, and local citizens and leaders; share health planning resource tools; and explore strategies to ensure that rural areas maintain a viable health sector. As a result of the conference, state rural health teams were formed in Alabama, Arkansas, Kentucky, Mississippi, Oklahoma, and Texas. This document contains minigrant reports from the six state teams. Each report includes an introduction, team objectives, activities, achievements, future plans, and contact information. In Alabama, a countywide Coosa County "family festival" focused on family health, parenting, and the particular needs of children. Arkansas team members participated in an intensive workshop on how to write and adapt health materials for low literacy individuals, and are developing a center to provide such materials on a continuing basis. The Kentucky team developed a resource directory of health services for Floyd County, addressed cultural awareness issues, and started a clearinghouse on health education issues. The Mississippi team established a mentoring program for at-risk teenagers in Jones County. The Oklahoma team guided Noble County community leaders through the process of making decisions to improve their health environment. The Texas team assessed health issues and related educational needs in Hunt County. (SV)

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Building Rural Health Partnerships in the South

Final Report to the W.K. Kellogg Foundation and the Farm Foundation

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Building Rural Health Partnerships in the South

Final Report to the W.K. Kellogg Foundation and the Farm Foundation

April 1999

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▶ Proposals Funded

State	Lead Organization
Alabama	Dr. Randall Weaver Coosa Action Network
Arkansas	Mike Hedges Cooperative Extension Service
Kentucky	Steve Fricker Center for Rural Health
Mississippi	Rachel Welborn Mississippi State University Extension Service
Oklahoma	Gerald Doeksen Oklahoma Cooperative Extension Service
Texas	Steven Shwiff Center for Regional and Economic Development Studies Texas A&M University-Commerce

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Project Summary

Communities in the South are facing a number of challenges in the health and public arenas. These include the rapid evolution of managed care systems and provider networks, the large number of uninsured and underinsured, and the focusing of public health on core functions. Unless communities are actively involved in addressing these challenges, they are likely to experience the imposition of solutions from external agencies with little regard to local issues and preferences.

Community leaders also realize that without a viable health sector, their community will not grow or prosper. The health sector is an extremely large employer, is needed for industrial and business growth, and is needed for attracting retirees. For all these reasons, it is clear why community leaders have a keen interest in insuring that their community has a viable health sector.

Rural community leaders often lack the data, information, and knowledge to conduct community strategic health planning. Some Southern state (Oklahoma and Kentucky) have developed state strategic health planning teams that have been extremely successful in assisting rural community leaders in the health planning process. The end result is a community plan that addresses their health issues and provides local residents quality health services.

The Southern Rural Development Center at Mississippi State University, in cooperation with the Southern Extension Research Activity-19 (SERA-19) set as a goal to stimulate the creation of new partnerships that enhance the capacity of rural communities to address key health issues. As part of that objective, the center hosted a conference in 1997 to

- Develop partnerships among the land-grant system, the health sector, and local citizens and leaders;
- Share health planning resource tools; and
- Explore strategies to insure that rural areas maintain a viable health sector.

As a result of the conference, teams were organized to address collectively the health-related issues of their respective states. In addition to 1862 and 1890 land-grant personnel, representatives from state offices of rural health and state departments of health, doctors, hospital administrators, citizens, and elected officials.

To add action to ideas generated at the regional conference, the SRDC, along with the W.K. Kellogg Foundation and the Farm Foundation, provided funds for mini-grants to six state rural health teams.

Alabama, Caring For Coosa's Children, *Dr. Randall Weavers*, Coosa Action Network—An interdisciplinary team organized by the state initiated a Coosa County-wide festival focusing on family health, parenting, and the particular needs of children.

Arkansas, Southern Center for Health Literacy, *Mike Hedges*, Cooperative Extension Service—These team members participated in an intensive workshop to learn how to write or adapt health-related materials for low literacy individuals, and they continue to work toward developing a center to provide these materials on a continuing basis.

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Kentucky, Implementing Community Implemented Decision-Making on Health Issues for Floyd County, *Steve Fricker*, University of Kentucky Center for Rural Health—This team took work already completed by community leaders in Floyd County and helped them implement several health activities, including developing a local resource book of health services, addressing cultural awareness of health issues, and developing a clearinghouse of health education issues.

Mississippi, ALIVE Jones County, *Dorian Rodgers*, Mississippi State University Extension Service—This team helped establish a mentoring program for at-risk teenagers in Jones County, which has an unusually high incidence of teen pregnancy. The mentors provide peer educational activities to enhance the self–esteem of youth and to educate them about the dangers of teenage sexual activity.

Oklahoma, Community Health Decision Making Process, *Val Schott*, Office of Rural Health—This team guided community leaders in Noble County through the process of making decisions to maintain and improve their health environment. The team is developing an action plan; however, turnover in key community leaders has delayed the finalization.

Texas, Health Survey, Steven Shwiff, Center for Regional and Economic Development Studies—This state team is conducting an ongoing assessment of Hunt County's health issues and educational needs, looking toward addressing these needs on a priority basis.

Mini-Grant Reports

Because the funding was distributed to six different state teams to fund a diverse group of projects, the outcomes, implementation, context, future plans, and dissemination are summarized for each specific project below. Each section begins with an introduction of the project showing context, followed by objectives, actions, achievements, and future plans.

■

▶ Alabama

Caring For Coosa's Children

Introduction

The total population of Coosa County, a rural area in east central Alabama, has been static for many years. In 1980, the population was 11,377, and the projection for 1997 was 11,554.

Per capita income in Coosa County was $12,964 in 1993, which was about three-quarters of the state per capita income and nearly 40 percent lower than the U.S. per capita income. The racial composition of the county in 1990 was approximately 65 percent white and 35 percent nonwhite.

Coosa County does not have a hospital, only one full-time family practice clinic, one satellite pediatric clinic, and one part-time satellite general practice clinic. The health department presence consists of one nurse and one environmental health technician. The county has two extension agents who conduct programs in a variety of family, youth, community, and natural resources areas.

In 1989, a group of agency and community leaders organized the Coosa Action Network, a nonprofit corporation to raise funds for projects in Coosa County. This organization stimulates community-based programs to improve the conditions of children in Coosa County.

Caring For Coosa's Children is an agency funded through the Coosa Action Network. The

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goal of Caring for Coosa's Children is to increase the parents' knowledge in the following areas—child development, child rearing, nutrition, parenting skills, positive discipline, and special needs children. Caring For Coosa's Children hosts an annual Family Festival, a one-day event that offers educational and fun activities for families.

Objectives

- To increase community awareness of children's health issues in Coosa County.
- To increase the Coosa County community's capacity to identify and respond to children and family health needs.
- To develop a model of mobilizing state agencies and organizations to assist local communities in identifying and responding to community health needs.

Actions

As a first step in bringing together cooperating organizations at both the local and state levels, these groups will work together to support and enhance the Coosa County Family Festival. This festival has been initiated by the Coosa Action Network and Caring For Coosa's Children. The Family Festival is a countywide event that focuses on family health, parenting, and the particular needs of children.

With the additional funding, advertising, follow-up, materials, and presentations for Family Festival were expanded. Other projects in Coosa County also were initiated. These expansions can be aided not only by an increase in funding but also by assistance as needed from the state partnerships that have developed in response to this grant and other similar grants. Funds also could be used to partially support community involvement in developing a strategic plan for addressing family health issues in Coosa County.

In the past, the meetings following the Family Festival began the planning process for the next Family Festival. The partnership developed an additional survey to assess what the participants of the Family Festival are areas of needed improvement in Coosa County. The survey will be used as a guide for the community assessment and strategic goal setting.

The state and local agency sponsors of this rural health partnership/state team collaborative project formed an interdisciplinary state response team bringing together people with backgrounds in health promotion, community and health assessment, economic development, health professions education, health care delivery and evaluation. This state team provided resource persons to the community in its planning and evaluation.

Achievements

The Family Festival was held on May 16, 1998. One hundred, eighty-seven people signed in at the registration table, less than in previous years. A possible cause of the decreased numbers is the festival being held later in the year. (The date for the 1999 Family Festival is currently being considered.)

The state partners or their representatives, were present and participated in varying degrees at the Family Festival and assisted the local team.

A wide range of health, parenting, and prevention information was available to all participants, including classes and seminars on specific topics.

Participants were asked to complete an evaluation of the Family Festival. The data were separated into two forms—histogram and statistics.

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Participants also were asked to complete a separate survey concerning problems faced by the children of Coosa County.

Future Plans

The results of the evaluation and the survey will be used to assist the teams in planning future Family Festivals and other community projects. One possible project is violence prevention. Caring For Coosa's Children has been offered funding to provide violence prevention education in the Coosa County elementary schools.

Additional Information

Data from the evaluation of the festival is available in both histogram and statistical form. Data from the survey concerning problems faced by children also is available. Contact Dr. Randall Weaver, Coosa Action Network, 205-377-4366.

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▶ Arkansas

Southern Center for Health Literacy

Introduction

In Phillips County, Ark., the issue of adult literacy is pronounced. Twenty-seven percent of the population have less than a ninth grade education and another 29 percent did not graduate from high school. Employment opportunities reflect these low educational levels, as indicated by the below $9,000 average personal income in this area compared to the national average of about $14,500.

Phillips County is a rural Delta county in Eastern Arkansas with a population of 28,238. Approximately 59 percent of the residents live in communities larger than 2,500 with no community size reaching 10,000 inhabitants. This part of the state depends on agriculture industry. Many of the employers do not provide medical insurance. It is estimated that 22 percent of the individuals have no health insurance. Fifteen percent of the population is 65 years of age or older, and this number is increasing each year.

There is one hospital in the county, one county health department, one rural health clinic, and three home health agencies. There are approximately 20 primary care physicians in the community with a large portion of these being 50 years of age or older.

Objectives

- To provide leadership for collaborative, multi-organizational effort in reforming health communication.

The leadership is developing a plan to establish a Southern Center for Health Literacy. The partnership participated in training and developed potential materials for local community organizations. The final product of the partnership will be a business plan, to be used as a basis for the solicitation of funds to develop the Southern Center for Health Literacy. The mission of the Southern Center for Health Literacy is to enhance the overall communication between clients and health professionals.

Actions

The partnership includes the following organizations—the University of Arkansas for Medical Science (UAMS), Arkansas Cooperative Extension Services, Arkansas Department of Health, Arkansas Literacy Councils, University Affiliated Program of Arkansas and the University

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of Arkansas at Little Rock. The initial activity of this partnership was to plan, organize, and conduct a three-day health literacy awareness and training workshop that was attended by 100 professionals from all regions of the state and three other states. Jane Root, nationally recognized expert in medical literacy, was a presenter at this conference. Participants included representatives from hospitals, clinics, public health, universities, literacy programs, extension services, adult education, rural development centers, insurance companies, pharmacies, and other health-related organizations.

Three partnership organizations (UAMS, the Arkansas Department of Health, and the Arkansas Cooperative Extension Services) worked with the Phillips County advisory committee in planning and implementing a local literacy program. The council identified the targeted audience that included health care professionals, educators, and providers. The council sponsored a workshop in May 1998 in Helena. The council provided copies of "Teaching Patience with Low Literacy Skills" by Cecilia Doak, Leonard Doak, and Jane Root; a notebook of examples of good and bad health literacy and copies of health-related brochures that had been rewritten to target a low literacy population. A pre- and post-test of the participants skills and knowledge level concerning medical literacy was conducted, and the results indicated that the individuals were not aware of the importance and impact of health literacy.

At the conclusion of the statewide training, the partnership developed a business plan they are now using to solicit funding for a Southern Center for Health Literacy.

Achievements

The partnership developed a pre- and post-test for participants at the local workshop. A notebook was assembled for distribution at the local workshop. A business plan, supported by all organizations included in the partnership, has been established.

It is felt that the activities of this project would be transferable to other states in the South. It is reasonable to think that the proposed Southern Center for Health Literacy, when funded, could provide the leadership and support for the expansion of health literacy in other portions of the south.

The members of the partnership continue to work together in their efforts to fund the Southern Center for Health Literacy and collaborating in other health-related issues.

Future Plans

A limitation to this project was the ability to secure and empower local residents to become engaged in the project. However, this was a driving force behind the partnership to develop a business plan for a Health Literacy Center. The issue of health literacy is a very broad issue. To engage local residents in health literacy programs, a support system for the local participants is needed. The partnership determined that a center could and would provide the necessary support to local communities.

As always, funding is a limitation to the continued development of a health literacy program. The interest generated through this project will be used in securing funds for future development of this project.

Additional Information

For more information, contact Mike Hedges, Cooperative Extension Service, University of Arkansas, 501-671-2156, mhedges@uaex.arknet.edu.

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▶ Kentucky

Implementing Community Implemented Decision-Making on Health Issues for Floyd County

Introduction

Health care providers and community members in southern Floyd County came together in a community-based planning process called Community Initiated Decision Making (CIDM) to determine the health care needs for their area. As a result of the CIDM process, a local Community Health Council recommended that

1. Doctor/patient relationships be improved throughout the health care system;

2. Local health care providers find ways, ideas, and resources to help educate and promote good health care within the community;

3. Health care providers cooperate with each other to benefit the community;

4. A health clinic be initiated in local high schools to address the high instance of youth problems, particularly teen pregnancies;

5. Better communication to the community exist about available health resources; and

6. Emergency medical (ambulance) services cover "blind spots" in the service area.

While service providers began incorporating many aspects of the community's recommendations into their planning and program efforts, community members continued to seek assistance in order to see the work they committed to in this planning effort come to fruition.

The project area consists of southern Floyd County and adjacent portions of Knott and Pike Counties in rural southeastern Kentucky. This area is in the heart of the Southern Highlands of the Appalachian Mountains. The project area has high poverty rates, barriers to health care services such as transportation and a lack of knowledge of available resources, and a lack of employment opportunities. The population of the target area is approximately 25,000 people, spread out in the mountainous terrain in small communities and hamlets.

Health care services in the region include county health departments and two regional health care centers, a 166 acute and 18 sub-acute bed facility in Prestonsburg, (in northern Floyd County) and a 221-bed facility in Pikeville (Pike County). In southern Floyd County, there are two small hospitals, one in McDowell (50 beds) and one in Martin (30 beds). These two facilities were the primary sponsors of the original CIDM process.

In addition to these services, there are several primary care/rural health clinics in the area. Many are satellites of hospital facilities mentioned above. There also are a number of physicians and dentists who serve the region. Another independent service provider is the Mud Creek Clinic located in southern Floyd County with a long-standing history of providing health care services to the area.

Objectives

The objective of this project was for the state team to assist a locally based Community Health Council in the Floyd County area in implementing health care need recommendations they had identified earlier. The recommendations were the result of a Community Initiated Decision-Making process that began in April 1996.

The formal CIDM planning effort ended in July 1997 with the development and presentation of the recommendations of the Community

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Health Council. These recommendations also provide a brief overview of the activities that took place as part of the CIDM effort.

Despite the end of the formal CIDM process in July 1997, community members, through the local council, demonstrated remarkable support in attempting to see that their recommendations were implemented. Five task forces were developed to address areas such as emergency medical transportation, cooperation among health care providers, youth services, health education resources and doctor/patient relationships. Health care providers in the area also responded. For example, one local hospital hired an individual whose primary duties are local community relations. In addition, the hospital also continued to provide salary support for the Community Encourager for an additional six months and she continues to provide volunteer service to the council, the task forces and serves as a State Resource Team member.

The state resource team, which included the local Community Encourager addressed three specific areas—development of a local resource book for use at the local level, addressing cultural awareness issues on the part of the community and their health care professionals, and development of a "clearinghouse" on issues relating to health education.

Actions

The State Resource Team members linked with the Community Encourager in Floyd County in the initial development of the mini-grant proposal. Since the Community Encourager had spent more than a year in activating the community around health care issues, she brought a wealth of local knowledge and network contacts in the area. Because of the community's experience with CIDM, there was already an existing network of community members and service providers in the form of the Health Council and various task forces.

Resource Directory

As a result of discussions between the Community Encourager, the Health Council, and the Resource Task Force, the primary focus for this effort was the development of a resource directory for the area that encompasses southern Floyd County and portions of Pike and Knott counties.

Members of the resource task force included health service providers, county extension agents, education personnel, and community members. These individuals provided support and guidance in identifying organizations that provided health-related services to the area. The Community Encourager provided staff support by collating this information, identifying of other resources, and providing initial layout of the resource directory. The State Resource Team members provided technical assistance, final graphic arts layout, and administrative support in the printing of the resource directory. The McDowell Appalachian Regional Hospital has volunteered to act as a central point of contact for additional distribution of the resource directory to the community and for keeping track of changes. As a community service, a regional printer has agreed to print 8,500 copies of the resource directory at a reduced rate.

Other Activities

Addressing issues of cultural awareness on the part of the community and their healthcare professionals was another desire of the Health Council. Two members of the Doctor/Patient Relationship Task Force and the Community

Encourager attended a one-day seminar on building rural health partnerships in Huntington, W.V. The focus of the seminar was on the use of alternative medicines, integration of modern medicine with the spiritual and emotional aspects and integration of doctor/patient relationships.

Achievements

A major tangible product developed as a result of this mini-grant is a resource guide which identified health services available in the immediate area of Southern Floyd County and adjacent portions of Knott and Pike counties. Throughout the CIDM process of individual interviews, surveys, small group meetings, and community meetings, there was a consistent pattern of a lack of knowledge among many community residents of the services in the area and how such services could be accessed.

Development of a small, concise resource directory that identifies emergency services, children/teen services, health clinics, counseling services, dental care, eye care, educational services, food pantries, general medical services as well as programs that assist with insurance and medication provides a tangible product that community members themselves can be actively involved in.

There are at least two aspects of this effort that are transferable to other communities. The first, development of a community specific resource directory, is easily transferable. Such an effort which moves beyond the simple line-listing of numbers from a telephone book, places community members into the valuable activity of resource identification. This type of endeavor also encourages participants to move beyond needs-based analysis and begin examining existing resources from within their community.

The second aspect of this effort is assisting communities that have committed to a community-based, citizen-involved planning effort. The notion of citizen participation in local decision-making is not new and its use is spreading, especially in addressing health issues. However, planning efforts take time and immediate feedback, i.e., tangible results from the work of citizen volunteers, can be slow in coming. There are many such efforts underway around the United States.

During the project time period, Resource Team members from the Center for Rural Health and the Cooperative Extension Service became participants in a national pilot project, Rural Health Works, sponsored by the Rural Policy Research Institute at the University of Missouri. Rural Health Works is geared toward documenting the economic impacts of the local health service industry and how critical health care is to rural development and service delivery. Information generated from this project will be used in local planning efforts for community health service delivery, so local leaders will be better able to make decisions to provide appropriate health care services and keep health care dollars at home. During this project, community level analyses will be conducted on existing health services and the economic impacts they have on the community. Floyd County is a natural choice to be included in the first group of Kentucky communities for the Rural Health Works project.

Future Plans

A potential disadvantage of this effort is the resource directory itself. Service directories quickly become out of date, they can become lost, or, in some cases, simply not used. In addition,

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they are rarely complete. A directory such as the one developed by this project must be distributed, as well as maintenance of additions and corrections through volunteer efforts. In the case of this project, a local hospital has volunteered to act as a point of contact for additional requests for copies and to maintain any additions or corrections.

Updating the directory has been discussed with members of the community. Suggestions include leveraging this first edition in the form of a "loss leader" where local health care providers and businesses may be willing to purchase advertising space to support future editions.

Another limitation of this project is that it relied on a pre-existing network and planning effort. This project directly supported recommendations that community members had already spent more than a year in developing. As a result, there was an immediate social network that the State Resource Team, via the Community Encourager, could tap to determine the wants and needs of the community. While this network was a major resource in itself, without it out, an entirely different strategy would have been necessary.

Additional Information

Copies of the recommendations from the Community Health Council and copies of the resource guide are available. For more information, contact Steve Fricker, University of Kentucky Center for Rural Health, 606-439-3557, rsfric00@pop.uky.edu.

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▶ Mississippi

ALIVE Jones County

Introduction

In February 1997, 25 Jones County community leaders met to formulate a process for identifying community health care needs. The project, named ALIVE Jones County, was initiated by South Central Regional Medical Center, the county's only hospital. An intense research phase involving data collection from 16 sources, including surveys sent to 10,000 Jones County residents, followed these initial planning meetings. Four key health care issues rose from the research findings:

1. *Moral and spiritual crisis*—A moral and spiritual crisis was considered a root cause of many community health issues such as teen pregnancy, domestic abuse, crime, and drug abuse.

2. *Teen pregnancy*—Mississippi has the highest teen pregnancy rate in the nation. In Jones County, 23 percent of the babies born in 1997 were to teen mothers. Other consequences of teen sexual behavior were equally alarming.

3. *Health care access*—Appropriate health care usage and responsible self-care decisions were two alarming issues in the health of Jones County residents. The problem was of particular concern with senior adults and teenagers.

4. *Nutrition and exercise*—Three key facts arising from the research pointed to a need for enhanced nutrition and exercise for Jones County. First, the rate of heart disease in the county was higher than the national average. Second, more than half of the survey respondents indicated they were overweight. Third, exercise was rarely or never practiced among 50 percent of the respondents.

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Throughout the analysis of the data, the need for teen self-care information and health care access, especially in the area of sexual behavior, became a prominent concern. While several agencies addressed pieces of the concerns, no effort had been made to coordinate and organize delivery. Uniting the community efforts and developing services to bridge gaps in teen health care became prominent objectives.

Jones County, located in southern Mississippi, has a population of approximately 63,000. Within the county, Laurel and Ellisville are the only cities that have a population more than 1,000. Laurel is the largest with a population just less than 22,000. Ellisville has a population of approximately 4,600, leaving nearly 64 percent of the county's population in a rural setting.

Three of Jones County's five major manufacturers are agriculturally-based. Two of these, Wayne Farms and Sanderson Farms, process poultry, and Howse Implement Company manufactures rotary cutters and tillers. Howard Industries, the largest Jones County employer, manufactures power and distribution transformers. Masonite Corporation, the third largest employer, manufactures coated and laminated hardboard.

Jones County's two public school districts enroll a combined total of just less than 12,000 students. In addition, Jones County Junior College, located in Ellisville, enrolls an additional 4,900 students each semester.

Jones County's only hospital, South Central Regional Medical Center, has a capacity of 285 patients, including nursing home and extended care. In addition, Laurel has one minor emergency care facility, and approximately 100 physicians serve Jones County.

Objectives

Two objectives, both focusing on teen health care needs, were pursued in this project. First, teen self-care skills were to be enhanced, especially in the area of sexual behavior. Second, teen usage of existing health services was to be improved. To accomplish these goals, a consultant team was needed to guide the community efforts.

Actions

In October 1997, ALIVE Jones County assembled a consultant team made up of representatives from 46 Jones County agencies that had a particular interest and/or expertise in working with teens. This team's mission was to develop a community-wide approach to encouraging healthy teen self-care choices regarding sexual activity. To enhance the progress of the committee, Mississippi State University Extension Service wrote a grant to hire a full-time Youth Health Educator to serve as coordinator of the team's efforts. This position was filled in November 1998.

Meeting monthly, the team accomplished several goals. Its first priorities were to assess current county health care delivery sources for teens and to generate a plan of action to guide future efforts. Once the first of these priorities was accomplished, a three-pronged deficit remained to guide the second priority. The team determined that for teen sexual abstinence to increase, efforts were needed to:

1. Enhance parent education,
2. Promote community awareness and support for the mission, and
3. Expand teen self-care education for teens and preteens.

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Community Awareness

The consultant team shared a concern that Jones County residents were unaware of the extent of teen sexual behavior and its consequences for the county. With nearly one fourth of Jones County's births being to teen moms, the teen pregnancy rate alone shocked many of the team members. Media, coupled with presentations to civic organizations, was believed to be the most effective way to broadcast the message. To assist with the message delivery, *The Laurel Leader-Call*, Jones County's only daily newspaper, printed a three part series on the issue, giving front-page coverage to each piece. Also, six "Health Break" television segments, sponsored by the hospital, have been devoted to the seriousness of teen sexual behavior. Presentations have been made to many community organizations, including the Rotary Club and the Ministerial Alliance, and brochure explaining the mission of the effort was produced.

Parent Education

Two parenting groups were targeted for service—parents of teens, to promote healthier relationships in which to communicate on sexual issues, and teens who were already parenting, to reduce the risk of subsequent pregnancies and to encourage healthy development of these babies who tend to have delayed development.

An assessment of parent services and needs showed that while some agencies in the county offered parenting education, the efforts were sporadic and unorganized. Parenting skills and information were lacking. Also, support for teen parents and for the grandparents in the three generation households that often resulted from teen pregnancy was needed to break the cycle of continued unhealthy sexual decisions. This deficit prompted a search for additional resources. To fill this gap, several sets of parenting curriculum are currently under review, with classes targeted for mid-spring 1999.

Another resource appeared in the form of a videoconference entitled "Grandparents Raising Grandchildren." Mississippi State University Extension Service hosted the program locally, inviting the consultant team and other area agencies to attend. This conference, designed to aid professionals in developing a comprehensive delivery system, served as a starting point for meeting the needs of these adults by bringing together nearly 40 community leaders who shared the concern.

Teen Self-Care Education

Through a review of successful teen self-care education programs centering on abstinence, three success factors emerged—a cohesive community-wide message, utilization of peer educators, and life skills education (assertiveness, decision making, communication, etc.).

Cohesive Messages

On July 1, 1998, Mississippi enacted a law that assisted in cohesion by setting a standard for sex education for the public schools. The law stated that if sex education is taught, sexual intimacy must be placed within the context of marriage. In keeping with this law, a cohesive message of choosing to wait until marriage to begin sexual intimacy was adopted by the Consulting Team. With the strength of the 46 represented community agencies, the Consulting Team served as a core for community cohesion. Efforts have been made

at broadening that support by presentations to other civic groups.

Life Skills Education and Peer Educators

The Consultant Team spent several months evaluating self-care curriculum, seeking these two success criteria of involving peer educators and teaching life skills. *Managing Pressures before Marriage*, written by Dr. Marion Howard, was selected as a beginning point. This curriculum, targeting young teens and preteens, promotes sexual abstinence until marriage through discussion, active learning activities, and role-playing. Students are taught important life skills such as:

- making responsible decisions,
- setting appropriate boundaries,
- handling pressure situations through effective communication and assertiveness skills,
- evaluating media and societal messages, and
- identifying appropriate sources of information to guide their actions.

The five-session curriculum content in heightened by utilizing older teen leaders as self-care educators. Eleventh and twelfth grade teens are recruited and trained to deliver the information to younger students.

To further enhance the cohesion of ALIVE Jones County's message, key community leaders were asked to review this curriculum and write letters of support for the message. These letters served to encourage school administrators to consider the program as well as to further educate the community on the project's goals.

Modeling the education program after a similar program in Choctaw County, Ala., the Youth Health Educator is currently working with school officials in both of Jones County's school districts to finalize implementation plans. The program is titled "Teens Getting Involved for the Future" (T.G.I.F.).

Rural Health Event

As efforts toward promoting healthy choices progressed, the importance of encouraging teen usage of existing services surfaced. One effort in this direction was the Rural Health Event that took place in February 1998 at Watkins High School, Laurel's only city high school. Break-out sessions covered such topics as "Sexually Transmitted Diseases," "Tobacco Usage," and other health issues. County agencies serving teens were invited to set up booths highlighting their services. Teen evaluations proved the event to be very successful. Plans for this year's event are well underway with 8th and 9th graders from both county school districts being included. Attendance is expected to be more than 2,000, with the school districts' cooperation in transporting students to the event during school hours. Because of the importance of the abstinence message, the keynote speaker and many of the booths will center on this message. ALIVE Jones County will be presenting each student with a self-care packet developed from existing resources.

Achievements

As growing support surfaces for an abstinence message, more and more organizations are developing matching educational material. Initially, the writers of this grant anticipated developing a newsletter to promote the message. However, in exploring options already available, a host of possibilities existed including parent education curriculum, teen self-care curriculum, and support material such as videos and brochures. Choosing from among the quality pieces available seemed

more efficient than attempting to create new material, aiding the team in creating a resource list of sources that were especially helpful.

While no two communities are identical, the goals and achievements of ALIVE Jones County could easily fit other communities that share a similar concern. Developing a quality Consultant Team is a vital step to success. Involving key community leaders and agencies early in the process will help promote a cohesive effort and prevent duplication of services.

With the tendency toward conservative values that exists in the South, the abstinence until marriage message is likely to receive more support than it might in other locations. The union between the abstinence message and community values is one of the strengths of Jones County's program that would likely be experienced in other conservative, rural communities.

Future Plans

ALIVE Jones County, the Consulting Team, and Mississippi State University Extension Services are committed to the continuation of this effort. Future plans include continuing and expanding the efforts discussed above. In addition, plans to coordinate parenting classes offered through other agencies as well as through this project are underway. The team hopes to develop a community calendar for teens and parents to advertise any services or programs that are offered in a given month. Also, efforts to expand the self-care training and Rural Health Event to reach a larger audience are being developed. Opportunities to share the message within the community will be sought as efforts toward community cohesion continue.

Cooperative efforts with Mississippi's Department of Human Services' Just Wait Campaign are planned. To compliment the work already accomplished, Just Wait will provide two billboards with abstinence messages beginning at the end of January 1999. The Consultant Team will be active in promoting Just Wait's campaign burst planned for May 1999.

While the extensive initial data collection process used in Jones County was a tremendous enhancement in this process, it was also very expensive and time consuming. Fortunately, the process was funded through South Central Regional Medical Center in Jones County. However, accomplishing this portion would be difficult without an agency or individual who is willing to initiate the efforts. While other communities may not have this resource to spearhead the project, initial organization could still be successfully accomplished by encouraging smaller interested agencies to unite and serve as a spearhead committee.

Another potential limitation is tied to the nature of the problem. Because sexual behavior is both a health and moral issue, some agencies and individuals are reluctant to approach the topic for fear of offending others with what may be considered moral education. However, emphasizing the health issues (pregnancy, STD's, etc.) has put to rest most opposition while encouraging agencies who are accepted moral promoters (churches, etc.) to join the effort.

Additional Information

Copies of the brochure explaining the mission of the effort are available, along with a resource list for abstinence education. For more information, contact Rachel Welborn, Mississippi State University Cooperative Extension Serivice, 601-428-5201, jones@ext.msstate.edu

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▶ Oklahoma

Community Health Decision-Making Process

Introduction

Noble County, Okla., decision-makers are concerned not only with maintaining the current level of health services but also with providing high-quality, necessary health services and with recruiting and retaining physicians and health care professionals. Although a regional health center is located near the county, there is a hospital located in Perry, the county seat. It has periodically been able to obtain a local tax supplement to assist with funding. The hospital has 73 percent Medicare utilization and 6 percent Medicaid utilization and is currently operating with a gain in revenue. The health care community in Noble County realizes the importance of their health care providers and that their survival is based on community support.

Noble County is a rural county in northwest Oklahoma with a 1996 population of 11,240. The county's population increased 1.8 percent from 1990 to 1996. The county seat, Perry, has a population of 5,060.

There are four smaller towns in the county but the majority of the balance of the population (4,380) live in the rural areas. The county has one large manufacturing industry, Charles Machine Works (i.e., Ditch Witch), and maintains a strong agricultural base.

The employees of Charles Machine Works have good insurance. Many of the citizens choose to travel to the regional health center in Stillwater (the next county, 25 miles away) for health care services. Noble County has one 28-bed hospital with an adjacent physician office building. There are six physicians located in the county, three dentists, two optometrists, and two chiropractors. Two nursing homes and one assisted living center are also located in the county. The county has a health department, several home health care agencies, and five pharmacies.

Objectives

The objective of the project was for the state resource team to guide Noble County through the community health decision-making process in order to address the community's health care needs. The Oklahoma Resource Team is striving to "evolve" the planning process by putting more focus on community involvement, continuation, and sustainability. The planning process was to include increased emphasis on development of the community steering committee. The emphasis was on community agency and organizational support to encourage long-term participation in the planning process.

The Resource Team was to guide the community through the process by providing facilitation services and development and presentation of the three products—economic impact of the health sector; demographic, economic, and health data and information; and the community health assessment tool.

The community's ability to sustain the steering committee and to continue the planning process each year was of utmost importance. More time was spent in the project to build commitment to the process from the community health steering committee members. More emphasis has been placed on the importance of an ongoing, continuing effort to maintain and improve the health care environment in the community and to try to obtain a "buy-in" to this concept from each steering committee member and especially from the community groups represented on the steering committee.

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Actions

Resource Team

The Resource Team included representatives from Oklahoma State University, Oklahoma Cooperative Extension Service, the Oklahoma Office of Rural Health, the Oklahoma Office of Primary Care, and the Oklahoma State Department of Health. The Resource Team provided project facilitation in guiding the local community through the community health decision-making process. The Resource Team also acted as support staff to the community facilitator (or contact person) and the community health steering committee.

The Resource Team prepared the economic impact of the health sector and presented to the community health steering committee. The Resource Team gathered the demographic, economic, and health data and information, prepared tables and illustrations of this data and information, and presented this data and information to the community health steering committee. The Resource Team assisted the community facilitator with publicity by preparing newspaper articles about the project activities. An inventory of the community health resources had been done the previous year and it was not felt that it needed updated this year of the community health decision-making process. Copies of the health economic impact, data and information, and community health survey results are available.

Community Health Steering Committee

The Community Health Steering Committee utilized a community facilitator to provide administrative support activities for the group. The local hospital, Perry Memorial Hospital, provided the community facilitator. The facilitator kept the mailing list up-to-date, made contacts with the local community representatives, including meeting notices through the mail and individual phone calls right before the meetings, and prepared and sent the newspaper articles to the local newspapers. The Resource Team assisted the facilitator with preparation of news articles. The facilitator also reviewed the make-up of the steering committee in conjunction with the current members and made contacts with additional individuals and organizations to expand the scope of the community health steering committee. Although additional organizations were invited to join the community health steering committee, the current members of the group felt the larger problem was keeping the current member organizations active. Assignments were made to several of the current members of the group to contact the absent organizations and try to get them involved in the group on a more active basis. One phone call from a current member seemed to bring the group back together and increased the attendance level.

Several personnel changes in the community also affected the attendance of the community health steering committee. What is so important about all the above community personnel changes is that the community health steering committee was able to survive and to continue with the project. The changes caused other members of the group to take the lead, to become a stronger presence in the group, and to realize the importance of the overall group effort in keeping the community health steering committee alive. The hospital had been the strong overall leader in the group and the Noble County Health Department, although they had always been actively involved, became a much stronger presence in the community health steering committee. Even if nothing else results from this project, the spirit of the

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community, its ability to overcome obstacles, and the actual survival of the community health steering group should be result enough to make the community of Noble County proud. The commitment to the community health steering committee and the continuation of the group looks very positive.

The community health steering committee provided excellent publicity for the community health assessment tool. For several weeks prior to the actual survey calls, the committee made a very successful effort to publicize the survey. Notices were put in several large employer newsletters—Charles Machine Works (Ditch Witch) and the Division 4 Oklahoma State Department of Transportation (Highway Department). Notices were also placed with the each employee's paycheck. The Noble County Health Department came up with a one-page flyer and, with the cooperation of the school system, this was handed out to all the school children at enrollment to take to their parents. An article was written and published in both newspapers, the *Perry Daily Journal* and the *Noble County Line*. When the survey was actually taken, it was done over a period of four days and, because of the vast amount of publicity, the number of survey responses was outstanding; a very low number of the survey calls refused to answer.

Achievements

The products developed from the Noble County, Oklahoma, community health decision-making process include the economic impact of the health sector, the demographic, economic, and health data and information, and the community health survey results.

Economic Impact Report

The economic impact of the health sector could be utilized as a model for any community. Access to the USDA IMPLAN multipliers is available to all states. The actual direct impacts of the health sector are obtained from the local community, showing the number of employees in each category, as well as the actual or estimated payroll for each category. The resulting total employment and income shows the actual direct impact of the health sector on the local community economy. With the use of the IMPLAN Type III employment and income multipliers, the secondary impacts of the health sector can be shown. By applying the multipliers to the direct impact of each category of the health sector, the secondary and total impact (the sum of the direct impact and the secondary impact) can be calculated for each category and for the total of the health sector. This gives an overall picture of the effect of the health sector on the local community economy.

The direct economic effects of the health sector on the economy of Noble County in 1998 included an estimated 292.5 employees with an estimated payroll of $6,820,500. However, the total effect of the health sector on the economy resulted in an estimated total of 458 employees and an estimated total payroll of $9,528,735. Retail sales tax at a one-cent rate would result in $28,586.

Demographic, Economic and Health Data and Information Report

The demographic, economic, and health data and information can be used as an example of the types of data that may be available. The national data sources are available to any community; these

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include the U. S. Census Bureau, the U.S. Census Estimates, and the Bureau of Economic Analysis, Regional Economic Information Service. The other data sources can be helpful to a state in locating similar data in their state. This publication shows the data areas that are available in Oklahoma, although it may not be all-inclusive. Each state will have different state resources available and this will have to be researched locally.

The selected data and information for Noble County showed that the Noble County population increased by 10 percent from 1970 to 1990 and by 2 percent from 1990 to 1996. The state has increased at a larger rate than Noble County, 23 percent from 1970 to 1990 and 5 percent from 1990 to 1996. The number of persons less than 65 years of age is larger in Noble County than the state; in 1990 the county 16.3 percent and the state 13.5 percent, in 1996 the county 16.7 percent and the state 13.5 percent, and projected to 2010 the county 19.3 percent and the state 14.9 percent.

The county labor force has increased from 5,590 in 1995 to 5,800 in 1997; employment has also increased, from 5,380 in 1995 to 5,600 in 1997. The unemployment rate in Noble County has been lower than the state for the years 1995-1997. In 1997 the county unemployment rate was 3.5 percent and the state was 4.1 percent. The selected data and information for Noble County showed the per capita income for Noble County has increased from $17,779 in 1996 to $19,203 in 1998. However, this is lower than the state per capita income, which increase from $19,629 in 1995 to $21,036 in 1998. Transfer payments as a percent of personal income have been larger for the county than the state; the county has 22 percent and the state 20 percent for the years 1996-1998.

Noble County poverty levels in 1998 are very similar to the state poverty levels. The number of persons less than 100 percent of poverty level represent 16.4 percent of the county population and 16.2 percent of the state population. The number of persons less than 150 percent of poverty level represent 26.3 percent for the county as compared to 27.2 percent for the State. The number of persons less than 185 percent of poverty level represent 34.4 percent for the county as compared to 35.0 percent for the State. The number of persons less than 200 percent of poverty level represent 37.3 percent for the county and 38.2 percent for the State.

The number of low birth weights in Noble County decreased 29 percent from the 1983-87 averages to the 1990-94 averages. The 1990-94 county average was 4.8 percent as compared to the State of 6.7 percent. Infant mortality decreased 36.7 percent from a 12.2 average annual rate per 1,000 in 1983-87 to a 7.7 average annual rate per 1,000 in 1990-94; the state decreased from 10.4 average annual rate per 1,000 in 1983-87 to 8.8 average annual rate per 1,000 in 1990-94. The births to teens age 15-17 decreased by 9.4 percent from the 1985-87 average to the 1992-94 average. Child deaths decreased by 64.9 percent from 1978-82 to 1990-94.

There has been an increase of 661.7 percent in child abuse and neglect confirmations from a rate of 1.3 per 1,000 in 1985 to a rate of 9.8 per 1,000 in 1995. Domestic violence, however, appeared to be low at a rate of 1.63 per 1,000, as compared to the state rate of 9.4 per 1,000. The high school dropout rate for Noble County of 5.4 percent appears to be comparable to the state rate of 5.5 percent. The juvenile violent crime arrests

increased from zero per 1,000 in 1980 to a 2.99 per 1,000 in 1995.

The percent of children living in poverty increased from 11.5 percent in 1980 to 21.6 percent in 1990. The percent of children who are AFDC recipients decreased from 7.7 percent in 1980 to 6.2 percent in 1990. Noble is ranked as the 18th top county in terms of income; it is in the wealthiest economic cluster.

The number of uninsured children (less than 185 percent of federal poverty income guidelines) represented 13.2 percent of the total population in Noble County in 1995. In 1997 over 1,200 persons were recipients of Medicaid, representing 11.4 percent of the total county population. In 1996, AFDC recipients represented 2.2 percent of the total population and food stamp recipients 9.3 percent.

In 1994, 25.4 percent of the total births were to single mothers and 17.8 percent of the total births were to mothers under age 20. In 1996, approximately 90 percent of the patients who visited the local community hospital were from Noble County. In 1994, 7.1 percent of those needing prenatal care received little, late, or no care and 5.1 percent entered into prenatal care during the third trimester. In 1994 only 3 percent of deliveries were made in the county.

In 1994, women in need of maternity services (less than 185 percent of the federal poverty income guidelines) represented 36 percent of total births. Also, in 1994, over 35 percent had less than 24 months interval between births, representing short interval births.

The average rate per 1,000 for brain injury incidence for 1992-95 was 116.9 for Noble County, which was high as compared to a 95.9 average rate for the state. The community had an average rate of 8.8 per 1,000 for spinal cord injuries in 1991-95, as compared to the state average rate of 4.9. The average rate per 1,000 for motor vehicle injuries was 30.0 for Noble County for 1991-95, as compared to the state average rate of 20.8. Noble County also had a higher average rate per 1,000 for burn injuries for 1991-95; 21.2 for Noble County as compared to 14.9 for the state.

The county had the same average rate per 1,000 of 3.5 as the state for submersion for the 1991-95 averages. For firearms for 1991-95, Noble County's average rate per 1,000 of 7.1 was considerably lower than the state's average rate of 16.3. For homicide for 1991-95, Noble County had an average rate of 7.1, as compared to the state of 9.2. Noble County was much lower than the state for the incidence of suicide for 1991-95—county average rate of 3.5 as compared to the state average rate of 14.6.

Based on the 1993-1995 age-adjusted three-year death rate per 1,000, for the leading causes of death, Noble County, the State of Oklahoma, and the United States had the same five leading causes of death (not in the same order).

For Noble County, the five leading causes of death, in order of the most to the least, were

1. cancer,
2. heart diseases,
3. accidents and adverse effects,
4. chronic obstructive pulmonary diseases, and
5. cerebrovascular diseases.

The next five leading causes of death for Noble County are

6. symptoms, signs and ill-defined conditions;
7. chronic liver disease and cirrhosis;
8. Diabetes Mellitus;
9. pneumonia and influenza; and
10. homicide and legal interventions.

The Hospital Utilization and Plan Survey from the Oklahoma State Department of Health shows

the 1995 data for Medicare and Medicaid enrollment; Noble County had 16.8 percent of the population enrolled in Medicare and 11.8 percent of the population enrolled in Medicaid in 1995. In 1996 Medicare patients represented 60.2 percent of all discharges and 75.1 percent of the total patient days and Medicaid represented 5.1 percent of the total discharges and 3.0 percent of the total patient days in 1996 from the community hospital in Noble County.

Live births for 1995 were 13.5 per 1,000 for Noble County as compared to 13.8 per 1,000 for the state. The death rate per 1,000 was 11.4 for Noble County in 1995, as compared to 9.9 for the state. The infant mortality rate per 1,000 was 5.1 for Noble County and 8.8 for the state for the 1990-94 average rates. For 1996, Noble County had 2.5 licensed hospital beds per 1,000 and 2.5 staffed hospital beds per 1,000, with 778 hospital admissions, representing 3,472 patient days. The occupancy rate for the community hospital was 34.0. For 1995, Noble County had 184 nursing home beds per 1,000.

Health Survey Report

The community health assessment tool is available as an example community health survey instrument. The questions asked in this community health assessment tool are available to be utilized by any community. The assessment tool can be presented to a community as an example and the questions can be modified or changed to adapt to the needs of the community situation. Additional questions or areas of concern can be added to the survey. Or an entirely new assessment tool could be developed, based on the individual community's needs.

The Noble County Health Survey showed that 82 percent of the respondents reported having good or better health. Eighty-eight (88 percent) of the respondents had private health care insurance. Of those respondents with health insurance, 44 percent reported insurance was provided through their employer, 29 percent reported Medicare, and another 18 percent reported their insurance was self-paid. Of the immediate family members of the respondents only 68 percent had insurance coverage; of these, 52 percent was provided through employers, 15 percent Medicare, and 16 percent self-paid.

Ninety-three percent of the respondents reported using a primary care physician for routine medical care. Fifty-nine percent reported their primary care physician was located in Perry; another 16 percent reported Stillwater; and 6 percent, Enid. Seventy-five percent of the respondents reported their last visit for a routine checkup was within the last year. Seventy percent of the respondents reported they obtained physician services in the county; 60 percent obtained hospital services in the county; 56 percent, dentist services; and 75 percent, pharmacist services. Nineteen percent of the respondents reported they obtained no health care services in the county.

More than 30 percent of the respondents reported that they travel between 10-20 miles one way for physician services; another 47 percent reported traveling between 20-50 miles one way. For hospital services, 29 percent reported traveling 10-20 miles and another 40 percent reported traveling 20-50 miles. For dental services, 29 percent traveled 10-20 miles one way and 36 percent traveled 20-50 miles one way.

Sixty percent of the respondents who have given birth in the past five years gave birth in Stillwater. Another 8 percent of the respondents gave birth in Enid and 4 percent in Cushing. No delivery services are available in the community's

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hospital. Only 36 percent of the respondents reported taking their children under age 12 to Perry for health care services; another 26 percent reported Stillwater.

Thirty percent of the respondents reported they smoke. Seven percent of the respondents reported they use smokeless tobacco products. Seventy-five percent of the respondents reported they always wear their seatbelts. Twenty-three percent reported they drink alcoholic beverages, at least one drink in the past month. Twenty-seven percent (27 percent) of these consume one drink per week; 12 percent, 2-5 drinks per week; and 15 percent, more than 5 drinks per week.

Seventy-five percent of the female respondents have had a mammogram; 84 percent of the female respondents over 35 have had a mammogram. Seventy-one percent reported they have had a mammogram within the past year; 75 percent of the females over 35 have had a mammogram with the past year. Ninety-one percent of the female respondents have had a Pap smear; of those over age 35, 90 percent have had a Pap smear.

Thirty-five percent of the respondents have received a pneumonia vaccination within the last 10 years; 45 percent have received a tetanus vaccination; and 21 percent have received a Hepatitis B vaccination. Fifty-six percent have received a flu shot in the past 12 months. Fifty-nine percent plan to have a flu shot this year.

Ninety-one percent reported they have smoke alarms in their residence.

Eight percent of the respondents reported they know or have known a community member with AIDS/HIV. Forty-two percent reported that the resources in the community are NOT adequate for AIDS/HIV diagnosed persons. Twenty-eight percent reported they would attend an AIDS/HIV educational opportunity for adults in Noble County, if offered.

Forty-eight percent of the respondents feel there are not adequate resources available in the community to meet the needs of pregnant teens. Sixty-eight percent of the respondents feel there is a need for additional adult assisted living facilities. Sixty-two percent of the respondents reported they would use an adult assisted living facility. Sixty-one percent of the respondents reported they would use adult day services, if available.

Sixty percent of the respondents feel there is a need for mental health services in the county. Seventy-six percent of the respondents reported there is a need for substance abuse services in the community. The respondents reported they felt adolescents age 13-18 was the age group in greatest need of mental health services, with a 32 percent response. Fifty-four percent of the respondents felt that adolescents age 13-18 was also the age group in greatest need of substance abuse services.

Sixty-one percent of the respondents felt there is a child abuse problem in Noble County. Sixty percent reported they feel domestic or spousal abuse is a problem. Forty-nine percent of the respondents reported they there are not sufficient abuse/violence prevention programs in the community. Fifty-one percent reported there are not adequate abuse/violence support and/or treatment programs available in the community.

The respondents reported that drugs/alcohol/tobacco/smoking is the most important health problem in the community. The second most important health problem was reported to be cancer.

All portions of the community health decision-making process developed and utilized in Oklahoma could be adapted to any community

situation. For instance, Noble County chose not to update their current inventory or directory of community health resources. However, all other areas of the project were completed.

The community health decision-making process should be modified to fit the particular community situation. Modifications will always need to be made. However, the basic process can be utilized anywhere. A Resource Team is not a necessity; however, the community health steering committee and its members will need to spend a much larger proportion of time on the process and the resulting projects if there is no Resource Team to provide these.

Future Plans

Oklahoma Cooperative Extension Service is staying heavily involved with the Oklahoma State Department of Health, as well as the Offices of Rural Health and Primary Care. Currently, both the Oklahoma State Department of Health and the Oklahoma Cooperative Extension Service are involved in a Kellogg grant project, Turning Point. The members of the Resource Team also are involved in teaching the Oklahoma Public Health Leadership Program.

The Resource Team members were very involved in development of the critical access hospital state plan. They are now in the planning stages to develop procedures to assist rural communities in the transition to critical access hospitals. Plans are for the team members to do the community plans and to assist with the implementation to critical access hospitals.

The importance of a Resource Team that can work together and provide support and follow through for each other cannot be overemphasized. This is a potential disadvantage. The coordination and communication between and amongst the Resource Team and with the local community health steering committee is also extremely important. A breakdown in communicating and coordinating can be, not only embarrassing, but can kill the entire community health decision-making process.

Funding the Resource Team is a major limitation. The Resource Team needs travel funds and survey funds. The Oklahoma Resource Team provides their time; however, travel expenses to and from the rural areas becomes quite high. Another limitation is the funding for the community health assessment tool, which is conducted via a phone survey. The cost includes conducting, tabulating, and analyzing the survey instrument.

Another limitation is the local leadership; many things can change the make-up of the community leadership. For instance, in Noble County, three major leaders in the steering committee changed in the last year due to death or personnel turnover (job relocating). This can cause a complete breakdown of the process or a major slowdown of the process. The steering committee was, however, able to overcome this in Noble County through their strength and dedication.

Another limitation could be the availability of timely state data. Each state may have different sources of data and information. When conducting the study for the first time, finding the data, obtaining the data on a regular basis, and synthesizing (or prioritizing) the data into a presentable format may take considerable time. After the first collection of data and information, it becomes fairly routine.

Additional Information

Copies of the community decision-making process used in Noble County is available. For information, contact Gerald A. Doeksen, Oklahoma Cooperative Extension Service, 405-744-6081, gad@okstate.edu.

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▶ Texas

Health Survey

Introduction

Hunt County total population for 1997 was 68,220 people with 20 percent between the ages of 0-19 years, 39 percent between the ages of 20-64 and 10 percent over the age of 65. Forty-nine percent of the population is male and 59 percent is female. The median age of the population is 37 years old. The wealth index for the county which uses the United States as a base of 100 is 75 indicating wealth levels 25 percent below national averages, and per capital income in 1992 dollars is $16,606.

The Texas Department of Health "Selected Facts for Hunt County 1996" gives a good overview of the County. TDH indicates 83 percent of County population as Caucasian, 11 percent Black and 5 percent Hispanic. The county fertility rate is 62.8 compared to 74.8 for the state and 9 percent of births are from mothers under 18 and 34 percent are unmarried women with a total of 26 percent having late or no prenatal care. Death rate from all causes is 560 compared to 520 for the state. Death rates from both cardiovascular (number one cause of death) and cancer (number two cause of death) exceeds state death rates significantly. County death rates from both injury accidents and motor vehicle accidents exceed state rates.

Objectives

- To design and implement an ongoing community-driven comprehensive model to assess and meet county health care needs and evaluate delivery systems. Initial assessment will include systems currently in place as well as unmet needs
- To develop an economic model to determine the county-wide impact of health care.

The first objective was spearheaded by the Hunt County Extension Service and Texas Agricultural Experiment Station Community Development Specialists closely coordinated by the County Steering Committee. Task forces will be named by the steering committee. The Hunt County Alliance for Economic Development is the initiating sponsor for the project. The steering committee represents the minority communities, health care providers, county and city governments, incorporated communities within the county, the business community, and educators.

The second objective was designed by the director for the Center of Regional and Economic Development Studies at Texas A&M University-Commerce. The IMPLAN model served as the basic analytical tool.

Actions

Hunt County Health Survey was conducted by random telephone survey methods and is still on going. Preliminary results are given in this report. It is expected that changes might occur in these initial findings when all surveys have been completed.

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Achievements/Survey Results

Demographics

Sixty-four percent of all respondents report living in families of 0-2 members. Forty-three percent of all respondents were between the ages of 20 and 30 with 16 percent over the age of 60. Eighty-six percent indicated they were Caucasian and 10 percent reported black and 67 percent were married. Seventy-eight percent of respondents were female. This results from the rather long length of the survey instrument. Experience indicates that males will simply not spend much time in answering a survey. Thirty-five percent were college graduates and 28 percent had incomes in excess of $50,001.

Health Status

Forty-six percent of respondents indicated that good nutritional habits were the top health priority for them while 44 percent indicated exercise and 38 percent indicated annual check up by a physician and 25 percent said regular dental care.

When asked to describe preventative health care sector behavior 40 percent indicated exercise, 29 percent said having annual check-ups and 24 percent said maintaining appropriate body weight.

When asked to describe their general health, 64 percent said good to excellent while 68 percent had at east one day when their physical health was not good during the past 30 days and 71 percent indicated at least one day in which their mental health was not good. Seventy-nine percent indicated that poor mental or physical health had prevented them from doing normal activities for at least one day.

Insurance

Ninety-four percent reported being covered by some kind of health insurance and financial reasons were the major explanation for not having insurance and most of those individuals had been without insurance for less than one year.

Forty-one percent report that payment for insurance is half them and half employer, while 26 percent said they paid all of the premiums, and 24 percent indicated employer pays the premiums. Eighty percent are satisfied with their insurance coverage.

During the past year, 30 percent reported insurance affected their choice of physician, 18 percent for hospital, 19 percent distance driven for health care sector, 15 percent access to health care sector, 10 percent impacted financial condition adversely, 13 percent impacted ability to obtain preventative care and 13 percent ability to obtain care which they though was necessary. Thus it does seem that insurance has no significant impact on access to the health system in the county.

Provider Issues

Ninety percent of respondents report there were no cases in which they wanted or needed health care sector but could not access it. For those who did not gain access, not having insurance was the primary reason for not gaining access.

Ten percent indicated they could not see a physician in the past year because of cost. Eighty percent indicate that there is one particular care center, doctor, etc., that they go to if sick or need advice. Seventy-nine percent had seen a health care sector provider during the past year and 13 percent during the past two years.

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Fourteen percent had used the Hunt County Health Department, and they were overwhelming satisfied (79 percent) with their experience.

Sixty-nine percent had used the services of the Presbyterian Hospital, and 80 percent indicated they were satisfied to very satisfied with their experience.

Sixteen percent indicated they had used the services of the Community Medical Clinic, and 70 percent were satisfied to very satisfied with their experience.

Five percent had used the services of Glen Oaks Hospital, and 73 percent were satisfied with that experience.

Forty-one percent had used another hospital, and 33 percent of those indicated it was a Dallas area hospital.

During the past year 65 percent had seen a medical doctor from 0-5 times; 91 percent, a dentist; and 96 percent a school nurse. Forty-six percent had seen a druggist 0-5 times but 40 percent had seen one more than 11 times. Eighty-four percent had seen a chiropractor 0-5 times, while 96 percent indicated the same for a psychologist, social worker, or counselor. Ninety-eight percent indicate use of home health care sector services at least five times as well as 96 percent for an ophthalmologist and optometrist. Ninety-five percent had seen a nurse practitioner 0-5 times and 99 percent had used a health phone line that many times.

Sixty-three percent drive less than five miles for medical services while 30 percent drive more than twenty and 67 percent drive less than five miles to a hospital and 23 percent drive more than 20 miles. Regarding seeing the dentist, 74 percent drive less than five miles and 15 percent report driving more than 20.

Seventy-nine percent use a primary care/family practice physician for most routine medical care.

Community

Thirty-seven percent of respondents would contact doctor/PA/nurse regarding what health services are available 21 percent family friend, 16 percent hospital and 12 percent phone book. When considering services available for the elderly, doctor was top ranked, then newspaper, then hospital and last was county offices. What was most is that a very few respondents indicated committee on aging.

As regards quality of health care sector family or friend was ranked first, then doctor, then "other." When asked the question of quality of a specific provider almost 50 percent of respondents indicated family or friend.

Economic Impact of the Health Care Sector

Hunt County ranked 43rd in total state county population in 1996 with 68,315 people. Per capita income of $17,949 was 80 percent of the state level of $22,324. Thirty percent of the county population of fewer than 20 years of age and 14 percent was over 65. Almost 21 percent of total earned income come from transfer payment of which retirement income accounts for the largest component.

The study team wanted to examine the impact that the health care sector had on the economy. As a result, four SIC codes were examined (490,491,492,493). The impact calculation follows.

Economic Impacts (Direct, Indirect, and Induced)

Industries in any region are broadly characterized as either export base or non-basic (support) sectors. The basic sectors generally produce

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products for sale outside of the region and as a result import money into the region. The non-basic sectors support the basic sectors. The idea behind this classification is that any economy will grow when it exports goods and imports money. Recent years have seen an extension of the concept of basic sector to include such activities as health care sector, tourism, and financial services.

Further, industries are classified by the Federal government's standard industrial classification system. The analysis focused on four health care sector related SIC codes, 490,491,492,493.

The "sales" made by the health care sector sectors along with purchases are referred to as direct economic effects.

Indirect economic effects are generated as the health care sector purchases inputs supplies from other regional industries. Money from sales entering the economy from outside the county generates additional economic activity within the city as goods and services are purchased in the health care sector production process. This demand for inputs stimulates production from the industries supplying the health care sector that causes them, in turn, to increase their demand for inputs into their own production process. These indirect economic effects result in additional jobs, increased income for the city and greater tax revenues for community infrastructure development.

The direct and indirect effects resulting from the health care sector industry provide for a third kind of effect on the city economy as wage earners, owners or managers spend their earned income and business profits within the city economy. These requirements placed on the city economy by the personal consumption of residents of the city induces additional activity in other sectors of the city economy as residents purchase goods, and services for daily living. This is referred to as the induced effect.

The total economic impact of the health care sector industry on the City is a summation of the direct, indirect and induced effects. The indirect and induced effects are often referred to as the secondary economic effects. Any increase or decrease in the health care sector output or sales may be expected to cause increases or decreases in secondary economic impacts throughout the remaining city economy.

The magnitude of the secondary effects of the health care sector within the city depends in large part upon whether the health care sector inputs are purchased from within or outside the city and whether the health care sector employees, owners, and mangers spend their wages and profits locally.

Clearly not all the money received from the sale of health care sector services nor income from the health care sector is all spent in the city. At each successive cycle of economic activity some money is lost from the city. Those losses are referred to as "leakages" from the city.

These leakages occur for a number of reasons including federal and state taxes that must be paid elsewhere, the need for specialized equipment and other goods and services that are not available within the city, and consumer preferences for shopping at locations outside the city.

In general, the magnitude of monetary leakage from a city decreases as the degree of economic integration and the availability of goods and services increase locally. As an extremely simplified example, suppose a manufacturer sells a product and receives $100.00 for it. He saves $5 in an out of county bank, pays $25 in taxes, and spends the balance of goods and services. The

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local marketing company is paid $20, saves $5 in a local bank, pays $10 in wages, and buys supplies some from local companies and some not. The employee buys from a local food store that is part of a national chain, etc. As one can see, the issue of leakage's from a region can become a complicated issue. Given the proximity of Greenville to Dallas, we have made assumptions, which increase the level of leakages.

The direct effects of the health care sector were provided to us by REIS database. However, estimation of the secondary economic effects of an industry on an economy requires the use of sophisticated computer models. Input-output modeling is an accepted methodology for estimating the secondary effects on an economy. The study team uses the computer based model IMPLAN (Impact Analysis for Planning). IMPLAN reflects the 1995 city level industry activity and the 1995 Bureau of Economic Analysis' accounting of industrial linkages.

IMPLAN was used in this study to estimate the economic interrelationships among major business sectors of Hunt County. In particular the focus was on dog, cat and other pet food.

The economic impacts of our unaggregated model of the county result from reducing all four health care sectors to "0". That is we assume that the entire health sectors disappear. We examine the impact by looking at total output and total employment.

Output Impact

Total: ($136,228,172)
Direct: ($86,866,151)
Indirect: ($21,790,833)
Induced: ($136,288,172)

Employment Impact

Total Jobs Lost: 3,049
Direct jobs: 2,233
Indirect Jobs: 309 Induced: 507

Thus the health care sector, in positive terms, contributes $136,288,172 in output effects and 3,049 in jobs to the Hunt County economy.

Additional Information

Details for the estimates of the coefficients for direct, indirect, induced, and total effects for output, income, employment, employee compensation, and value added are available. Information about the impact of the health care sector without aggregation of economic sectors and the economic impact of the health care sector using a one digit SIC code aggregation scheme also are available. For more information, contact Steven S. Shwiff, Center for Regional and Economic Development, Texas A&M University, Commerce, 903-886-5679, Steve_Sshwiff@tamu-commerce.edu.

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Southern Rural Development Center
Box 9656
Mississippi State, MS 39762
601-325-3207
601-325-8915 (fax)
http://www.ext.msstate.edu/srdc/
sandyp@srdc.msstate.edu

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